# DEPARTMENT OF HUMAN SERVICES

# FATALITY REVIEW REPORT

## FY 2008

**Compiled by**
**Department of Human Services**
**Office of Services Review**
**August 1, 2008**

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# DEPARTMENT OF HUMAN SERVICES
# FATALITY REVIEW ANNUAL REPORT

**JULY 1, 2007 – JUNE 30, 2008**

## EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open case at the time of death or in cases where the individuals or their families have received services through DHS within twelve months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2008, one hundred seventy-one deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were five suicide deaths (3%) and fourteen homicides (8%). The reviews indicate that abuse and/or neglect were contributing factors in twenty-two (13%) of the one hundred seventy-one deaths. Nine children, 15% of fatalities reported by the Division of Child and Family Services (DCFS), died as the direct result of abuse or neglect by their parents/caretakers. The deaths of six individuals (8%) receiving services through the Division of Services to People with Disabilities (DSPD) can be linked to failure on the part of the caregiver to follow safe practice procedures.

Of the sixty fatalities reported by DCFS, fifty-one reviews were held (85%) with nine reviews pending. Sixty-six of the seventy-seven reported DSPD fatalities were reviewed (86%) with eleven reviews pending, and three of the four Division of Juvenile Justice Systems (DJJS) fatalities were reviewed (75%) with one review pending. On-site reviews for the four reported Utah State Developmental Center (USDC) fatalities are pending, and Utah State Hospital (USH) conducted ten on-site reviews (100%). Three reported deaths from the Division of Aging and Adult Services (DAAS) met Department criteria for review, and those reviews are pending. The Office of the Public Guardian (OPG) reported the deaths of seventeen individuals for whom they had provided services. Four of these individuals (24%) were also receiving services through DSPD or USDC at the time of their deaths. OPG provided comprehensive written reports detailing services provided to all seventeen (100%) of its clients.

There were eighty-nine (52%) reported deaths of male clients and eighty-two (48%) reported deaths of female clients. Reported deaths included twenty-five infants (15%) under the age of one year; forty-seven (27%) clients between the ages of one to eighteen years; fifty-one (30%) clients between the ages of nineteen to fifty years; and forty-eight (28%) clients between the ages of fifty-one to ninety years.

# BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

The fatality review committees consist of a Board member of the Division under review, the Attorney General or designee for the Division, a member of management staff (supervisory level or above) from the designated Division and from a region other than that in which the fatality occurred, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee, a member of the Child Welfare Legislative Oversight Committee, and invited individuals whose expertise or knowledge could significantly contribute to the review process. The Child Fatality Review Committee is strengthened by the participation of a pediatrician who is also a member of the DCFS Board, a representative from the Division of Substance Abuse and Mental Health, and by the Director of the DCFS Professional and Community Development Team. The Director of Professional and Community Development provides a vital link between the committee and DCFS as she and her team develop or strengthen training to address identified problematic patterns of practice.

The DSPD Fatality Review Committee utilizes the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. Their medical knowledge and insight into health and safety issues is of great value to non-medical committee members.

Notification of client deaths is received through Deceased Client Reports, Certificates of Death, the Office of the State Medical Examiner, newspaper obituaries, emails, etc. The Department of Health provides the Fatality Review Coordinator with Certificates of Death for every child between the ages of birth and twenty-one years who dies in the State of Utah. These certificates are checked against the child welfare database, SAFE, to determine if the child or his family has had services within twelve months of the death. If services were provided within this time period, the Coordinator requests and reviews the family's DCFS case file, makes a written summary of the family's history of involvement with the Division, and analyzes case practice and agency culpability.

Prior to the monthly DSPD and Child Fatality Review committee meetings, members receive copies of fatality review reports to study and to note areas for discussion. When deemed appropriate, the Committees invite Division staff and/or contract providers to committee meetings to provide additional information. Following the committee review, the fatality review reports, complete with committee concerns and/or recommendations, are sent to the DHS Executive Director, the Director of the Division under review, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, a plan of action for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Systems, the JJS Committee meets on an as-needed basis.

In FY 2008 the Child Fatality Review Committee instituted a process to waive the formal committee review process for cases in which there are no practice concerns or in which there is no indication that Division practices contributed to the death of the child. The written summary of services for waived cases follows the same format as that for reviewed cases with the addition of the Coordinator's recommendation that the formal review process be waived.

The full report is then reviewed by the Child Fatality Review Committee Chair, currently the Director of the Office of the Guardian ad Litem, and by the Director of the Office of Services Review. If the Chair and Director concur with the Coordinator's recommendation to waive the formal review, they sign off on the recommendation. Child Fatality Review Committee members are provided with the Findings and with the Systemic Analyses of waived cases. Committee members can request a full review of any case for which the formal committee review has been waived.

Fatality Review reports are classified as Private/Protected. The content of the fatality report, i.e., the summary of services to the individual and/or his/her family is classified as "Private". The Fatality Review Committee's analyses of concerns regarding practice and the Committee's recommendations to the Division are classified as "Protected". Applicants for copies of fatality reports must meet GRAMA criteria for these classifications. An Executive Summary that meets GRAMA specifications is available for public release.

The DHS Fatality Review Coordinator represents DHS as a member of the Multidisciplinary Child Fatality Review Committee (MCFRC), which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The MCFRC is a collaborative process that includes professionals from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

The MCFRC meets with the Utah State Medical Examiners on an as-needed basis to review the deaths of children whose deaths occur under violent, suspicious, unattended, or unknown circumstances and to review the deaths of children who have committed suicide. Committee members pool information regarding prior services to and/or involvement with the decedent/decedent's family, identify causes of preventable deaths, make Child Protective Services referrals, make recommendations for follow-up services when appropriate, attempt to identify interventions that could prevent future deaths, and provide information to law enforcement during child homicide investigations.

The MCFRC has been instrumental in creating a Suicide Task Force, in partnering to complete a six-phase Youth Suicide Study, in working toward more comprehensive child-restraint and seat belt legislation, and in developing news releases, public service announcements, and media events to address the most common injuries among Utah's children.

# FINDINGS

The purposes for reviewing a Department of Human Services client death are to assess the Department's culpability in that death, to develop means for preventing future client deaths, and to improve services to children and adults who receive services through the Department. The review itself evaluates the system's response to protecting vulnerable clients. Committee members attempt to assess if "best practice" was followed during the provision of services to individuals and families.

During FY 2008, the DHS Fatality Review Committees received reports of the death of one hundred seventy-one individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in 163 cases (95%), services provided to the clients and/or their families did not contribute to the clients' deaths. In two DCFS fatalities (3%) and in six DSPD fatalities (8%) a relationship exists between the clients' deaths and failure on the part of workers or contract providers to follow best practice procedures.

A thirteen-month-old male died as the result of blunt force trauma to his abdomen inflicted by the mother's boyfriend who was the baby's primary caregiver. The infant's pediatrician reported bruising on the tops of both ears, and the infant's mother reported bruises of unknown origin on his back. Based on the signs of physical abuse, the fact that a non-related male was caring for the child, and the fact that multiple non-related adults lived in the home and provided care for the baby at different times, a thorough assessment of the mother's protective capacity was warranted but not conducted. Nor did the worker request a medical consult with professionals trained in recognizing signs of physical abuse. Three days after the CPS investigation was concluded the infant died of the inflicted injuries. Mother's boyfriend was charged with Child Abuse Homicide.

A three-month-old male died from asphyxiation after his father held him face down for an extended period of time in an effort to stop the baby from crying. DCFS Intake received a report of unexplained bruising on the baby's stomach and assigned the Priority II case to the worker of an already-open CPS investigation regarding this family. Within business hours that day the worker made two unsuccessful attempts to see the baby. However, at the conclusion of the day he did not pass the case on to the on-call worker, and he made no additional visitation attempts the following day. Two days following receipt of the report of suspected abuse, hospital personnel informed DCFS of the baby's death and reported that the infant had extensive unexplained bruising on his body. The father subsequently confessed to having smothered the baby. He was arrested and booked for Child Abuse Homicide.

A seventy-four-year-old male lived alone and was judged capable of reliably taking his own medications. He was funded for Professional Medication Monitoring services that included one-on-one RN services for the maintenance of a medication regimen and for ensuring that all pill-dispensing aids were suitably stocked and refilled. However, a provider staff member had been setting up the man's medication box on a weekly basis. After staff was hospitalized and had been on sick leave for at least three weeks, it was learned that no one had taken over the responsibility of setting up the individual's meds and that the provider RN had failed to check on the individual's medication status. Provider staff found the man dead in his apartment. The man had been treated for congestive heart failure, and he required consistent administration of medication. The lack of medication for an extended period of time contributed to his death.

When a seventy-nine-year-old medically-fragile female fell at her group home on a Saturday, provider staff failed to report the incident to the DSPD Support Coordinator

and failed to have the woman examined by medical personnel. In a visit with the woman four days after the fall, the DSPD Supervisor noticed that the woman was not as responsive as normal and that she had a bruise beneath her chin. Provider staff reported that the woman had been complaining of pain in her back and noted that the woman was scheduled to see her doctor in two more days, which would be six days after the incident. At that appointment the woman's physician admitted her to the hospital. Four days after being admitted to the hospital the woman died of acute myocardial infarction.

A fifty-seven-year-old male with a mental health diagnosis exhibited signs of being over-medicated with anti-psychotic drugs. The DSPD RN visited the man in the hospital and recognized the signs of Neuroleptic Malignant Syndrome (NMS). She suggested to the nurse practitioner at the hospital geriatric psych ward the possibility that the man had been over-medicated and that he was showing signs of NMS. The nurse practitioner was not familiar with this syndrome. The DSPD RN suggested that a drug holiday might allow the man an opportunity to come out of his unresponsive state. The DSPD RN also noted signs of dehydration and suggested that the man receive liquids intravenously. The following day the man's condition worsened, his family made the decision to have all life-support equipment removed, and he died. The DSPD RN suggested that had the man been treated immediately for NMS, had he been maintained on medical supports for a reasonable period of time, and had his family not authorized the removal of life-support systems so soon, it is highly possible the man would still be alive.

A forty-four-year-old male with a diagnosis of congestive heart failure was prone to contracting pneumonia, had extremely limited communication skills, and had an aversion to receiving medical treatment. Provider staff were cautioned to monitor the man's health closely and to insure that he received necessary medical treatment. The provider's residential manager visited with the man and noted that he exhibited symptoms of a fever. Instead of getting medical help for the man, the manager encouraged him to call if he needed anything or if he did not feel well. The following morning provider staff found the man dead in his apartment. The exact cause of death is unknown, as no autopsy was performed, and the man's family had him cremated.

While on an activity in the community, a cognitively and physically disabled thirty-year-old male turned blue. Provider staff increased the man's oxygen level before calling the Para transit to pick him up. When transportation was slow in arriving, provider staff transported the man to day program center and once again increased the man's oxygen level. During lunch, the man had what resembled a seizure, and the condition continued for more than twenty-five minutes. During this time, staff called the man's mother who then called the man's doctor before instructing staff to call '911'. It was ten minutes before the paramedics arrived, and it then took them another ten minutes to determine how to get the man on the gurney. During a medical procedure at the hospital, the man fell from the examination table. Because he had no ability to catch himself, he hit his head and suffered some injury. While hospitalized, the man experienced breathing problems, lost all mobility except the ability to blink one eye, and was told that he would have to use a breathing tube for the remainder of his life. The man indicated that he did not want to live in that condition and chose to have life support removed. Although it is impossible to say definitively, the delay in accessing medical assistance could have contributed to the man's death.

A forty-five-year-old male was admitted to the hospital and was treated for dehydration and anemia after he collapsed at his group home. The man's doctor made an Adult Protective Services (APS) referral, as he suspected abuse. According to the doctor, the man was malnourished, was covered with infected bedsores, and weighed only 110 pounds. In the hospital the man received nourishment through a feeding tube and gained some weight. The DSPD Support Coordinator denied knowing that the individual had

bedsores, and there were no reports from provider staff regarding bedsores or any other health concerns. Weight and food-tracking charts for the most recent months were missing, and the man had not seen a doctor in some time. The man died of pneumonia while hospitalized.

Of the sixty reported child fatalities sixteen deaths (27%) were attributed to abuse or neglect by a parent or caretaker. In addition to the cases mentioned above the following children died as the result of abuse or neglect:

A one-month-old male died of Haemophilus Influenza – Type A, the same illness that several weeks previously had caused the death of his maternal grandmother who was one of his primary caretakers and in whose home he lived. The child's mother, who reportedly was low functioning, did not understand the seriousness of the grandmother or the baby's illnesses and did not seek medical attention for either of them. The mother also indicated that she did not know that the grandmother's illness was contagious. The allegations of Child Endangerment and Medical Neglect resulting in death were supported, and the baby's siblings were court ordered into State's custody.

A nine-year-old female, a seven-year-old male, a three-year-old female, and their mother died of carbon monoxide poisoning and drug intoxication during and prior to a house fire intentionally set by the children's mother. Protective Supervision Services to the family had been terminated seven months prior to the incident based on the pledge of the maternal grandfather that he would ensure his daughter continued to attend therapy and to take anti-depressant medication.

A five-year-old male died of blunt force injuries sustained when he wandered away and fell from cliffs behind his home. The family has an extensive history of involvement with DCFS regarding neglect and non-supervision issues. Prior to the child's death, there had been incidents of the child's leaving the house undetected and placing himself in physically dangerous situations. The parents, who were well-meaning but low-functioning, were not committed to or capable of taking the necessary safety precautions to keep their son safe.

A four-year-old male, a three-year-old female, and their father died of conflagration injuries in a motor vehicle fire intentionally set by the father. The children's parents, who were divorcing, were embroiled in a custody battle. Several days prior to the children's deaths, DCFS unsupported an allegation of Physical Abuse made by the father naming the mother as alleged perpetrator. During the course of the investigation, both the DCFS supervisor and a law enforcement officer expressed the opinion that the case was primarily a custody issue rather than one of abuse.

A six-week-old female died of acute head injuries inflicted by her seventeen-year-old father who was her primary caretaker while the mother was at school. The infant also showed signs of having been sexually abused. One month prior to the infant's death the father had been supported for the sexual abuse of a fourteen-year-old female. The father moved in with the baby's mother and the maternal grandparents the day after the baby's birth. There was no DCFS history pertaining to the mother or her family. Criminal charges are pending against the father.

A seven-year-old male died as a passenger in a head-on collision. The child's mother, who was driving the car, tested positive for having multiple drugs in her system, and she was charged with third-degree felony automobile homicide. DCFS had investigated three reports of the parents' alleged prescription drug abuse but had been unable to support the allegations in two cases and had been unable to complete the investigation on the most recent reported abuse, as the family had left the state.

While caring for his two-month-old daughter, a father inflicted significant brain trauma by aggressively shaking the baby. Results of a medical examination indicated that the infant had old and new blood in her head, and the autopsy revealed that the baby had prior injuries to her upper arm and shoulder area and a broken spine. DCFS had supported allegations of Emotional Maltreatment – General and Physical Abuse perpetrated by the mother's former boyfriend on her then two-year-old son and had unsupported a report of non-supervision on the mother. The father is incarcerated and has been ordered to stand trial on a charge of first-degree felony murder.

A developmentally-delayed six-year-old male died after suffering blunt force injuries to his head and torso inflicted by his stepfather. The boy was hospitalized six days after the close of a CPS investigation in which an allegation of Physical Abuse on this same child by an unknown perpetrator was unsupported. Less than two years prior to the boy's death, he had been the victim of physical abuse by another stepfather. The stepfather has been charged with first-degree murder.

A nine-year-old male died of hypothermia after his sister and her employer placed him in a garbage can filled with ice water as a disciplinary measure. The pair has been charged with first-degree felony murder and one second-degree felony count each of child abuse and obstructing justice. At the time of the child's death DCFS had open Protective Supervision Services and Intensive Family Preservation services with the family to address several supported reports of physical abuse.

A ten-year-old female, her mother, and a one-year-old female died of multiple gunshot wounds to the head inflicted by the infant's father before he took his own life. In the year before the homicides DCFS had investigated and unsupported two reports of physical abuse against the father, had conducted a Home and Family Risk Assessment, and had unaccepted three reports of suspected emotional abuse in which the father was the alleged perpetrator.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the Health and Safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better assessments of parents' and children's underlying needs, better matching of level of services to level of risk of harm, and better monitoring of contract providers. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

# DIVISION OF CHILD AND FAMILY SERVICES

**SYSTEMIC STRENGTHS**

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continued to improve over casework conducted prior to the advent of the Practice Model. In the majority of cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, aggressively sought appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are conducting Child and Family Team Meetings and are working more closely with clients in an attempt to identify client needs and to plan appropriate services. During the past year, workers have been trained on the Safety Model which places emphasis on assessing a caretaker's capacity to protect. Some examples of good casework include:

Committee members noted commendable casework in two cases involving Domestic Violence related child abuse. In the first case the CPS worker made face-to-face contact with the children and contacted collateral contacts including the maternal grandmother, the paternal aunt and uncle, and the Victim Advocate. The worker obtained copies of medical and police reports and notified the area DCFS DV Specialist of the DV incident. The second worker obtained a case extension in order to monitor the family's follow-through in obtaining a mental health evaluation for the child and in accessing additional services. The worker referred the mother to the DV Specialist who assisted her with preparing housing paperwork and who secured clearance for the mother to go to the women's shelter

An in-home worker provided extensive supports to a family whose son was a homicide victim. The worker provided the family with a Spanish-speaking Parent Advocate and with translators for interviews and court. The service plans have been translated into Spanish, and the In-home and Family Preservation workers have been bi-lingual. The worker coordinated certain aspects of the investigation with the Mexican Consulate. The mother has completed a psychological evaluation, and her daughter was referred for a mental health evaluation. The family was provided with financial assistance for their child's funeral through Crime Victim Reparations.

In a CPS investigation related to the death of a child the worker immediately staffed the case with the Assistant Attorney General (AAG). Based on the allegations of abuse and on safety concerns, a warrant for the removal of the siblings was drafted and court ordered. The worker consulted with the Medical Examiner and provided him with medical records. When it was determined that the child's death was from natural causes and that there was no suggestion of abuse or neglect, the worker staffed the Medical Examiner's findings with the AAG who implemented the legal process to have the children returned to their parents as quickly as possible. The worker staffed the case for in-home services, and the family has been compliant with and pro-active in seeking the services outlined in their service plan.

During an investigation of a report of severe physical abuse, a CPS worker coordinated his investigation with law enforcement, arranged for the siblings to be interviewed at the Children's Justice Center (CJC), interviewed collateral contacts, and corroborated information provided by the mother. The worker staffed the case with the DCFS Neighborhood Administrative Team and with the AAG, made a referral for a Family Preservation assessment, set up a random drug-testing schedule for the mother, held

Child and Family Team Meetings, implemented a safety plan pertaining to drugs in the home and to physical discipline of the children, assisted the mother in applying for Medicaid, childcare, and other assistance, connected the mother with an Hispanic therapist who worked with mother/child bonding, and referred the mother to the Children's Center for a mother/toddler group attended by Latinas. Because of the mother's cooperation with DCFS, plans to file a petition for Protective Supervision Services were put on hold, and the mother and children are currently participating in voluntary in-home services.

A referral was made alleging physical abuse by an unknown perpetrator of a child suffering from a brain tumor. The CPS investigator saw the child within priority timeframes, observed the bruising, and interviewed the child's mother, teacher, and school principal. The worker also visited the child's home and observed him as he played in the backyard. The case was staffed with a committee that included a medical doctor familiar with the child. Based on the worker's interviews, his personal observation of the child's propensity to fall frequently, and the input of the child's physician, the worker closed the case with a disposition of "unsupported" for physical abuse.

**SYSTEMIC WEAKNESSES**

In FY 2008 the Child Fatality Review Committee noted in FY 2008 noted some patterns of practice that denote systemic weaknesses among the sixty reported fatalities. The following issues raised the greatest concern among committee members. It is recommended that during FY 2009, DCFS concentrate on improving case practice in these areas.

***Corroboration of Information and Lack of Follow-through in Providing Services***

A systemic weakness identified by the Child Fatality Review Committee during FY 2008 was the failure of some workers to corroborate information given by parents and/or alleged perpetrators regarding their compliance in obtaining and participating in services. Some workers also demonstrated a lack of follow-through in providing services to families. In at least fourteen of the fifty-one cases reviewed (27%) the Committee noted these deficiencies in case practice.

A CPS worker investigating an allegation of non-supervision failed to corroborate information provided by the mother. Although the mother provided the worker with names and telephone numbers of friends who reportedly cared for the child at night, there was no documentation that the worker contacted these care givers, nor did the worker contact the daycare that reportedly cared for the child while the mother was at work or the therapist who reportedly was working with the child.

A mother with an extensive history of involvement with DCFS and who was skilled in saying that which she perceived to be expedient, reported that her daughter's dental issues had been addressed and that her baby's immunizations were current. However, the worker did not corroborate this information with the dentist or with the baby's doctor. The worker did not follow through with having the mother drug tested, and she did not corroborate the story the mother told about the reason for her incarceration.

In an investigation into alleged drug use by a mother and stepfather the worker discounted the detailed description given by the "bright and articulate" five-year-old child regarding his seeing pot, meth, and a bong in his home, of seeing his mother smoke "it" out of a bong, and of seeing neighbors come to the apartment to get meth from his parents. There was no documentation indicating that the worker spoke with neighbors or with acquaintances that might have had first-hand knowledge of the parent's behaviors and habits. The parents eventually submitted to a drug test, the results of which were negative. In a second CPS investigation the parents tested positive for Methadone and admitted to being in possession of and taking prescription medications that were not

prescribed to them. The worker did not complete the investigation, as the family moved out of state. A year later the mother drove her vehicle into a ditch and was arrested and convicted of driving with a measurable amount of a controlled substance in her body. Two months later the mother was the driver of a vehicle involved in a head-on collision in which her son suffered a fatal skull injury. The mother was charged with third-degree felony automobile homicide, felony drug possession, and two misdemeanor counts of drug possession.

An in-home case was opened for a mother who was a victim of domestic violence and for her daughter about whom there were reports of suspected drug abuse and depression. Despite the mother's failure to follow through with obtaining a mental health assessment for her daughter or with obtaining DV counseling for herself, the worker closed the case. Eventually, the daughter was removed from the home and was placed in foster care. Although the daughter appeared to be doing well in foster care and was making plans for living on her own and for pursing a career, she obtained heroin in the community and took a fatal overdose.

***Voluntary (PSC) vs. Court-ordered Services (PSS)***

In at least four out of fifty-one cases reviewed (8%) voluntary in-home services were opened for clients who had extensive histories of drug abuse and/or who were non-compliant in accessing services or with pursuing treatment objectives.

After giving birth a mother and her newborn daughter tested positive for meth. The mother, who acknowledged that she had been a daily meth user for two years, repeatedly failed to report for drug testing, cancelled her drug and alcohol assessment, lied to the evaluator and to hospital staff about drug treatment, and was inconsistent in visiting her baby and in learning to care for her. After the baby's discharge from the hospital DCFS opened a voluntary in-home services case. The mother failed to drug test or attend substance abuse treatment, repeatedly left the baby with the grandmother for extended periods of time, failed to maintain the baby's medical card, and falsified drug-test results. After six months of voluntary services the court ordered Protective Supervision Services (PSS). However, there is no indication that the case was treated as court-ordered services, and it was transferred to another office as a PSC case. Five months after the court ordered services the case was opened as PSS. Four months later the baby was removed from her mother's custody and was placed with the grandparents whose home was eventually licensed for foster care.

During a CPS investigation into an allegation of physical abuse by a father against his 13-year-old daughter, the worker learned that that there was a history of domestic violence between the parents. The AAG suggested that the worker attempt to gain cooperation from the family through voluntary services before pursing a PSS petition. The father refused offered services, but the mother accepted them and indicated an interest in obtaining help with domestic violence issues and with learning parenting skills. The mother cancelled a scheduled Child and Family Team Meeting when the child overdosed on aspirin. The child refused mental health services from the hospital social worker but agreed to see her school counselor. The counselor reported concerns that the girl was involved in substance abuse and about suicidal comments she had written in her notebook. Despite repeated requests that the mother schedule a mental health assessment for her daughter, she did not do so and justified her behavior by minimizing her husband's behaviors. After voluntary services had been open for six months the mother again agreed that within the coming week she would schedule a mental health assessment for her daughter and would contact a DV counselor for herself. When the mother did not comply, the In-home worker closed the case.

During the next three years, the family's older daughter died of a drug overdose while in JJS custody. The daughter in the CPS investigation was ordered into DHS custody with DCFS providing case management and JJS funding the case. While in custody the girl died of a self-induced heroine overdose.

***Documentation Issues***

Deficits in documentation were noted in four cases (8%). Workers failed to document critical events such as changes in placement, removal information, court hearings and their outcomes, etc., or their documentation was not completed in a timely manner.

The death of a child brought to light the fact that the family's Family Preservation worker had made no substantive activity log entries in the four months the case had been opened. Despite the supervisor's documented admonition concerning the need for the worker to keep logs and other recordings current in order to preserve accuracy and despite the fact that the court ordered the continuation of PFP services, the PFP worker had made no additional activity log entries in the three months since the child's death.

A maternal aunt and uncle were given custody and guardianship of their niece and nephew because of the substance abuse issues of the parents. Seven years later the guardians' two daughters disclosed lewd behavior by their male cousin. CPS investigations were conducted into this report and into subsequent disclosures of sexual abuse made by both the perpetrator and the victims. During the course of these investigations, the workers allude to the fact that the perpetrator was in a treatment facility; that the guardians did not want the perpetrator to return to their home; and that the perpetrator had been ordered into DJJS custody. There is no documentation explaining how the alleged perpetrator ended up in a treatment facility when law enforcement did not press charges against him for lewdness; there is no documentation explaining when or why the perpetrator was moved from one facility to another; and there is no documentation explaining what led to the perpetrator's being ordered into DJJS custody.

## DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. If Regions accept the Committee's recommendations, they are asked to submit an action plan outlining how they will implement Committee recommendations.

The DCFS Constituent Services Specialist tracks Child Fatality Review recommendations and ensures that regions are responding to the Committee. At the close of Fiscal Year 2008 the Division had responded to all concerns and recommendations made by the Child Fatality Review Committee. The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the Regions and the Administrative Team have provided to the Committee's concerns and recommendations.

The Committee recommended that DCFS Administration review Practice Guidelines regarding the inadvisability of using children as translators for their parents in a CPS investigation. Division Administration felt that the topic applied to the entire system, not just CPS. DCFS Program Administrators are scheduled to discuss adding a Practice Guideline for all practice areas addressing the use of children as translators.

In response to a recommendation that the Professional and Community Development Team formulate a general training for CPS workers on recognizing the signs of physical abuse, the Division responded that a specific portion of Core training is dedicated to training workers on how to identify signs of abuse and neglect. However, the Director of the DCFS Professional and Community Development Team indicated that her team will

look at the curriculum to re-evaluate its effectiveness. In connection with the issue of physical abuse the Professional and Community Development Team, in conjunction with DCFS administration, will discuss the addition of a Practice Guideline addressing bruising found on any child or infant's core.

The Committee questioned whether foster parents received training on how to search foster children's rooms for drugs and drug paraphernalia and on how to look for and recognize signs of drug usage. The Utah Foster Care Foundation reported that their curriculum does not include specific training on the issue of substance use by foster children. DCFS requested that the Foundation add some instruction on this topic to the pre-service training provided to foster parents.

Southwest Region agreed to review with Intake workers Practice Guidelines pertaining to Intake's ability to accept a report of "neglect" rather than "medical neglect" when the report comes from someone other than a medical provider. The training was to be accomplished in team meetings with completion to be verified through team meeting minutes.

In response to a recommendation that the Division examine and if necessary, clarify Practice Guidelines with regard to the procedure workers should follow when they suspect physical abuse and that CPS workers be trained on the correct procedure to follow in these instances, Northern Region initiated a process to address policy and procedure guidelines on a monthly basis with all CPS workers in the county.

In addition the Division began training on the newly-developed Safety Model during FY 2008. The model emphasizes the assessment of a child's safety as being central to Intake and CPS workers' decision making and vital in visitation and reunification decisions made by on-going workers. The training provides language for caseworkers to use in talking about safety, additional information on assessing for safety, and an emphasis on making continual assessments for safety throughout the life of a case.

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# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## COMMUNITY PLACEMENTS

**SYSTEMIC STRENGTHS**

DSPD Support Coordinators act as advocates for individuals who are receiving services through the Division and through its contract providers. They verify and provide appropriate documentation necessary for ensuring an individual's eligibility for waivered services, provide crisis intervention when necessary, monitor the delivery and appropriateness of contracted services, review monthly provider reports, and assess an individual's well-being through in-person visits in the home or at day-support sites. The DSPD Fatality Review Committee recognized the excellent work of several Support Coordinators and recommended that they be commended for their outstanding work.

Staff from several contract providers were recognized by the Committee for their excellence in caring for individuals and for their exceptional efforts to provide comfort to individuals suffering from terminal medical conditions. Staff from REM, Northeastern Services (NES), Danville Services, TURN Community Services, COSH, United Cerebral Palsy, and WAC, were commended for their outstanding work.

> Due to the excellent care she received from Danville Services group home staff, a terminally-ill woman was allowed to remain in the group home until her death. Staff painstakingly pureed or thickened the woman's food to minimize the risk of aspiration. They proposed supervising visits between the woman and her mother after the mother allowed her daughter to have foods that could easily be aspirated. Danville staff agreed to provide services for the individual as her health worsened and to cooperate with Hospice Care if the service was necessary. Staff honored the woman's request to have a luau even though the woman died before the scheduled celebration.
>
> An individual living at home was receiving Supported Living services through the United Cerebral Palsy day program. The man's mother reported that her son was "grumpy" when he could not attend his day program and that if it were possible, he would attend the program seven days a week. The individual was provided with the opportunity to participate in community outings and to increase his work skills.
>
> Tri Connections and Valley Personnel staff encouraged an individual to eat nutritious meals, to drink water in place of soda, and to exercise. Staff assisted the man in planning healthy meals, in shopping for nutritious foods, and in packing healthy lunches for work. Staff ensured that the man took his prescribed diabetes medications, and they monitored his blood sugar levels twice a day. The individual was provided with transportation service in the winter, as he had a propensity to fall if there was snow or water on the ground.
>
> A woman with a lengthy and complicated medical history received conscientious care from Danville staff. The woman had been hospitalized several times in the months preceding her death and had spent time in a skilled nursing facility. Danville staff utilized Home Health Care staff to assist them in caring for the woman in areas for which they were not trained. Danville staff recognized that the woman required care beyond that which they were contracted or able to provide, and they urged DSPD to find a more appropriate placement for her. DSPD was in the process of locating such a placement when the woman was hospitalized and subsequently died.

REM staff provided compassionate and attentive care for an individual as his physical condition deteriorated. The RAS committee approved a budget increase to cover the expenses of enhanced staffing ratios to meet the man's needs. The increased services allowed the man to remain in his home until the day before his death.

A man with a dual diagnosis indicated that his work at Utah State Hospital provided him with meaningful activity and with the ability to earn money. The man, who had a good rapport with his job coach, was reported to be a good worker and to have an improved attitude while at work. Despite the man's tendency to be grumpy and somewhat intolerant of others, Tri Connections staff worked well with him and provided him with caring support and friendship.

An individual who was diagnosed with colon cancer required transportation to a neighboring city for extensive chemotherapy and radiation treatments. NES staff, who were trained in the use of therapeutic supports through verbal prompts, assisted the man to medical appointments. Due to the man's history of aggressive behavior, staffs' service was a health and safety guard for both the man and for the medical professionals who treated him. Between treatments Home Health Care came to the individual's home on a daily basis to keep the man clean and free of waste around the affected area and to treat a rectal fissure with zinc oxide. The Support Coordinator requested and received additional funding for respite care, which allowed the individual to continue chemotherapy treatments.

The DSPD RN's continue to provide an excellent resource for Support Coordinators in dealing with the health and safety issues of individuals in service. Many of the individuals receiving services through DSPD and its contract providers are diagnosed with numerous medical and/or behavioral problems for which they receive treatment and prescription medication. Individuals who are immobile are subject to skin breakdown that can lead to serious, and even life-threatening, wounds. RN's visit with individuals in their homes, in hospitals, and in care centers to make assessments of their medical condition and to monitor their progress and the quality of care they are receiving. The RN's have knowledge of prescription medications, their uses and possible side effects and can monitor the effectiveness and/or appropriateness of these medications. In some instances the RN's act as a liaison between medical professionals and providers, family, and DSPD, and they participate with hospital personnel in discharge planning. The Committee recognizes the excellent work of the DSPD RN's in all regions.

**SYSTEMIC WEAKNESSES**

In the majority of cases reviewed in FY 2008 the level of care for individuals appears to have been appropriate and provided as contracted. Individuals were provided with multiple services, excellent medical, dental, and mental health care, and opportunities to participate in meaningful work and community and social activities. Provider staff worked with several individuals in planning and shopping for nutritious meals and in encouraging them to exercise in order to reach or maintain a healthy weight. With the help of respite and supported living services thirty-three individuals were able to remain in their homes and to be cared for by family members.

During FY 2008, the DSPD Fatality Review Committee noted some concerns related to the delivery of provider services and to other systemic issues.

***Provider Incident Reports and Monthly Summaries***

Four of the sixty-six cases reviewed (6%) indicated that providers either failed to provide Incident Reports to DSPD or that some Incident Reports presented sketchy accounts of a medical emergency or accident. In another case the provider was not providing DSPD with monthly summaries as contracted.

In the case of a man who received delayed emergency medical assistance after having breathing problems while on a community outing and for whom provider staff delayed in accessing emergency medical assistance, the incident reports provided only a sketchy account of the episode, with few details and with no timeline of events.

A woman fell at her group home, but TURN staff did not report the incident to DSPD. Several days after the incident, a DSPD supervisor noticed external bruising on the woman. However, staff failed to submit Incident Reports concerning the woman's fall, her subsequent visit to the doctor, her hospitalization, and her death. When staff finally submitted reports, they made no mention of the woman's back injury. The DSPD supervisor indicated that TURN had repeatedly ignored its contractual responsibility to provide DSPD with incident reports in a timely manner. She also noted that the information TURN did provide in reports was "substandard, vague, and inconclusive".

A man sprained his hand and arm after falling on ice outside his apartment. Two weeks later he injured his hip and back when he tripped over un-hung doors in his recently-remodeled apartment. Mosaic staff did not inform the Support Coordinator of the individual's injuries, and there are no Incident Reports in the case file pertaining to either of these injuries. Although the Mosaic Residential Manager assured the Support Coordinator that she would provide him with Incident Reports, none have been provided. The Mosaic monthly progress notes mention in passing that the individual fell, hurting his hip and lower back. However, there is no mention of the fall earlier in the month when he sprained his hand and arm.

***Prompt Medical Attention***

In four of the sixty-six cases reviewed (6%) providers did not access medical attention for an individual in a timely manner.

While taking a group of individuals on a community outing, Achieve day program staff noticed that a man was turning blue. Staff adjusted the man's oxygen flow at least twice, a procedure that required an order from a doctor, transported the individual from the library to the day program center, called the man's parents, who in turn called the man's doctor, all before calling for emergency medical assistance.

A woman fell at her group home, but staff did not report the fall nor did they seek immediate medical attention for the woman even though she was complaining of pain in her back. Five days after her fall the woman was seen by a doctor and was hospitalized. Several days after being admitted to the hospital the woman died of an acute myocardial infarction.

A man who had extremely limited communication skills, an aversion to receiving medical attention, and a propensity for contracting pneumonia was not feeling well and was showing signs of a fever when he was visited by the Mosaic Residential Manager. Although it was clearly stated in the man's Person Centered Plan, Individual Service Plan, and Social Summary that staff needed to be aware of the individual's medical issues and that they needed to monitor his health closely and provide him with necessary medical treatment, the Residential Manager left the man alone without seeking any medical attention and with the admonition "to call at any time if he needed anything or did not feel well". The individual was found dead in his apartment the following day.

Chrysalis staff found an individual unresponsive on the floor of his apartment. She called another staff member requesting that he come to the apartment. When the second staff member arrived, he instructed the other staff to call '911' while he called the apartment manager. The '911' dispatcher instructed staff to turn the individual on his back, to clear his airway, and to give him 400 chest compressions. Staff followed these instructions until the EMT's arrived. However, the individual could not be revived.

***Casework Documentation***
In five of the sixty-six cases (8%) the Committee noted deficiencies in the recording of caseworker activities. The Committee recommended that workers be trained on proper documentation with an emphasis on recording their assessment of the individual's well-being, his progress, needs, and the appropriateness of services.

One worker's summarization of provider monthly reports was repetitive and uninformative. The worker appeared to use one or two variations of the entry on alternate months with an occasional new sentence added.

Another worker's activity logs consume multiple printed pages, yet they are composed primarily of cut-and-paste copies of the provider's monthly summaries. There is little documentation of the Support Coordinator's actual casework. It was recommended that the worker include a brief summary in his logs rather than the entire report.

Cutting and pasting information from one individual's document to another's sometimes results in incorrect information being transferred. A Support Coordinator cut and paste a provider's Residential Behavioral Progress Report and a Behavior Plan into his activity logs. However, the information included an incorrect birth date, incorrect start and stop dates, and an incorrect diagnosis for the individual.

Two workers' documentation of visits with individuals were cryptic, sparse, and contained little or no meaningful information regarding the individuals' progress, the appropriateness of services, and the individuals' well-being.

***Fiscal Agent***
It was documented in five of the thirty-three cases (15%) in which families used a fiscal agent that the families were dissatisfied with the services provided by ACUMEN. One family expressed frustration about ACUMEN's delay in paying respite employees. Three families either changed or indicated that they planned to change fiscal agents. Two families indicated that although ACUMEN's service delivery had been poor in the past, it had "greatly improved" during the past year.

## DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action they initiated to comply with recommendations, and for their formal written responses to the Fatality Review Committee. In response to the Committee's recommendation that staff be trained/in-serviced on the need to call '911' first in a medical emergency, Danville Services provided the Committee with the signed attendance sheet of staff who were trained on CPR and First Aid Protocol by the Danville Western Region LPN. Danville now trains staff that they are to call '911' before they call anyone else.

In order to prevent a lapse in medication management Tri Connections has compiled a list that specifies how medications are set up for each individual, including the person responsible, the day and time medications are set up each week, and the roles and responsibilities of staff in observing those individuals who fill their own medication boxes. The training was to be completed by January 2008, and a review of medication set-up procedures is to be done with all staff on a quarterly basis. Program Coordinators have been instructed to review and update written schedules for each individual and to provide additional training to all staff on reading and following written schedules.

Following the death of their client, Mosaic staff received in-service training on recognizing signs of physical illness and on when it is appropriate to seek medical intervention. These topics were to be addressed periodically with staff with the next training scheduled for August 2008.

DSPD supervisors indicate that they have addressed the components of good documentation with their support coordinators. They have also conducted reviews to ensure that documents are placed in the appropriate individual's file.

## UTAH STATE DEVELOPMENTAL CENTER

The deaths of four individuals were reported by the Utah State Developmental Center (USDC). All four individuals died at American Fork Hospital, American Fork, Utah. Formal death reviews are pending for these individuals and will be held at USDC when officials have received all medical records and other pertinent information concerning the deaths.

Natural Causes is listed as the manner of death for the four individuals. One individual died of aspiration pneumonia, another of acute asphyxia from aspiration of vomitus, and a third from atherosclerotic coronary artery disease. The cause of death is pending in the case of the fourth individual.

# DIVISION OF AGING AND ADULT SERVICES

During FY 2008, three reported fatalities from the Division of Aging and Adult Services and one fatality from DSPD/DAAS met DHS fatality review criteria. Each individual died of natural causes with two dying in hospitals and one dying at home.

The three individuals were reported as victims of alleged abuse or neglect, and the reports were investigated by Adult Protective Services (APS). APS investigators conducted thorough investigations into reports of Caretaker Neglect, Financial Exploitation, and Emotional Abuse/Harm and made dispositions based on information gathered and assessments made.

# DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

## UTAH STATE HOSPITAL

During FY 2008, Utah State Hospital reported the deaths of ten individuals who were receiving or who had received services within ninety days of their deaths. Four individuals were open for services through USH at the time of death; three individuals committed suicide after release from USH; one individual died at home, and the manner of the individual's death is pending; and two individuals who had been discharged from USH died in hospitals.

One individual, who was on his seventh admission to USH, suffered from numerous medical problems in addition to his psychiatric issues. During his hospitalization, the individual became severely ill with pneumonia and required admission to Utah Valley Regional Medical Center (UVRMC). His mother, who had power of attorney, requested that life-sustaining procedures be withheld and that her son receive "comfort measures only" and not be sent to UVRMC for another bout of serious medical care. The patient suffered two more episodes of pneumonia, and Utah State Hospital staff managed the illnesses on the unit. However, a third bout of pneumonia was fatal. Unit staff, the hospital social worker, and medical staff were commended for doing an excellent job of meeting the needs of the individual.

Another individual who received treatment at several treatment facilities before being admitted to USH had been hospitalized for more than five months. One evening the individual vomited and complained of abdominal pain. The following morning two RN's assessed the individual's condition and found her abdomen distended without bowel sounds. The individual was transported to UVRCM by ambulance and later was diagnosed with a perforated bowel. The individual died the following day.

A third individual on her fourth admission to USH was receiving treatment for multiple mental health and medical conditions including Morbid Obesity, Hypothyroidism, Esophageal Reflux, Seizure Disorder, Irritable Bowel Syndrome, Asthma, Edema, and Hypoxemia. One evening the individual was observed going into cardiac arrest. USH staff performed CPR and called for emergency medical personnel. The individual was transported by ambulance to UVRMC but medical staff were unable to revive her. The cause of death was determined to be a pulmonary embolism.

Three individuals' deaths were certified as suicides and the manner of death for one individual is still pending the results of the Utah State Medical Examiner. One individual was admitted to the hospital as "not competent to proceed" with charges of Attempted Murder, Aggravated Robbery, and Aggravated Assault. The individual responded to medication prescribed for psychosis and for depressive symptoms, and eventually her judgment and insight improved. It was determined that competency was restored, and the individual was sent to Utah State Prison. Two months later the individual was found hanging from a ligature fashioned from a bed sheet. The individual was resuscitated and was admitted to the hospital but died four days later.

Another individual was admitted to USH after two suicide attempts. He had symptoms of major depression and anxiety but did not present with symptoms of paranoia, hallucinations, or delusions. The individual did not meet the criteria for being dangerous to himself or others and after three months of treatment, he could not be kept in the hospital any longer. Although USH staff felt that discharge to a group home would be preferable, the individual's mother wanted him to return home. Two weeks after being discharged the individual took his own life by a self-inflicted gunshot wound.

Despite the recommendations of another individual's treatment team and of court examiners, a judge refused to renew the court commitment of an individual who was hospitalized for the fourth time. USH staff expressed concern that once discharged, the individual would stop taking his prescribed medications and would resume the use of illicit drugs. Approximately six weeks after his discharge, the individual stole a gun and shot himself. The USH Clinical Director and the Superintendent were to review the transcript of the individual's final civil commitment hearing and would propose further action after they completed their review.

Another individual had been suicidal prior to her third admission to USH. In the Intensive Treatment Center the individual was able to stabilize her emotions and deal with issues surrounding Post Traumatic Stress Disorder (PTSD). She was discharged from USH after a successful trial home leave. The individual complied with recommendations to continue with mental health services with "attention to substance abuse issues". At the time of her death, she was involved in day treatment services, case management, and doctor's services. However, the individual was found dead at her home, and the death is unofficially attributed to drug poisoning (Alprazolam, promethazine, and Hydrocodone). The official manner of death is pending results of the Utah State Medical Examiner's autopsy report.

The deaths of six individuals were certified as being from natural causes. Four of these individuals were hospitalized at the time of their deaths, one individual died at USH, one individual was in a care center.

Fatality review recommendations included creating a different set of "flags" for assessing the risk factors for patients who do not seem to fit the mold of normal USH patients. It was suggested that staff look at conducting more formal suicide assessments, although the two psychologists in pediatric services are working under a staggering workload. Requests for an individual to do psychometrics on a full-time basis have not been met.

A new pediatric discharge form has recently been implemented on which USH staff document treatment recommendations and mental health centers document what is actually carried out in an effort to track compliance and/or discrepancies in follow-up treatment. It was suggested that patients discharged from inpatient care need to be regarded as high-priority individuals when scheduling appointments through the mental health system.

The Utah State Hospital Clinical Director and the Clinical Risk Manager conducted on-site Risk Management Fatality reviews for each case. Due to the reclassification of DHS Fatality Review reports as Private which creates the possibility of HIPPA violations, USH no longer provides DHS with reports of its reviews.

# DIVISION OF JUVENILE JUSTICE SERVICES

The Committee received notification of the deaths of five Division of Juvenile Justice Services (DJJS) clients. The manner of death of three youths is listed as "undetermined" with the cause of death in two of the cases certified as "acute opiate toxicity" and as "blunt force injuries of the head" in the third case. One youth died of natural causes, and one youth died of injuries sustained in a motor vehicle accident. Two youth were in JJS custody at the time of their deaths with one being in community-based placement and the other in a group home.

At the conclusion of a weekend visit with his father, one youth brought prescription medications into the group home that he had stolen from his father. The youth died later that night of a drug overdose. Law enforcement felt that the overdose was accidental. A youth in a community-based placement died of a self-inflicted opiate overdose.

A third youth died of complex skull fractures, subdural hemorrhage, and prolonged post-injury survival interval (hours) without medical assistance. Reportedly, the youth, who was "grossly intoxicated", fell down a flight of wooden stairs. His friends thought he was "passed out" and took him into the apartment "to sleep it off". The youth did not receive medical assistance for approximately fifteen hours after he sustained the injuries.

**SYSTEMIC STRENGTHS**
In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive assessments and services that included individual and group therapies, medication management, life skills training, substance abuse treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

**SYSTEMIC WEAKNESSES**
The DJJS Fatality Review Committee did not identify any practice concerns or systemic weaknesses in the cases reviewed.

# OFFICE OF THE PUBLIC GUARDIAN

During FY 2008, the Office of the Public Guardian reported the deaths of seventeen individuals for whom they had provided guardianship services. Two clients were also receiving services in community placements through the Division of Services for People with Disabilities. and two clients were receiving services through the Utah State Developmental Center. Six individuals were hospitalized at the time of their deaths, nine individuals died in care centers, one individual died at Utah State Developmental Center, and one individual died at home with hospice care. The manner of death for all clients was "natural causes".

The OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients' service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

# DEPARTMENT OF HUMAN SERVICES
# FATALITY REPORT
# SUMMARY
**FY 2008**

| DEPARTMENT/DIVISION | Number of Reported Deaths | Cases Open at Time of Death | Cases Reviewed | Reviews Pending | Male | Female |
|---|---|---|---|---|---|---|
| **DEPARTMENT OF HUMAN SERVICES** | **171** | **121** | **143** | **28** | **89** | **82** |
| **DAAS** ***(Division of Aging and Adult Services)*** | 3 | 0 | 0 | 3 | 1 | 2 |
| **DCFS** ***(Division of Child and Family Services)*** | 59 | 19 | 50 | 9 | 28 | 31 |
| **DCFS/DSPD** *(Division of Child and Family Services/Division of Services for People with Disabilities)* | 1 | 1 | 1 | 0 | 1 | 0 |
| **DJJS** *(Division of Juvenile Justice Systems)* | 2 | 2 | 1 | 1 | 2 | 0 |
| **DJJS/DCFS** *(Division of Juvenile Justice Systems/ Division of Child and Family Services)* | 2 | 1 | 2 | 1 | 2 | 0 |
| **DMH - USH** ***(Division of Mental Health - Utah State Hospital)*** | 9 | 4 | 9 | 0 | 5 | 4 |
| **USH/DJJS/DCFS** *(Utah State Hospital/Division of Juvenile Justice Systems/Division of Child and Family Services)* | 1 | 1 | 1 | 0 | 0 | 1 |
| **DSPD/DAAS** (Division of Services for People with Disabilities/Division of Aging and Adult Services) | 1 | 1 | 1 | 0 | 1 | 0 |
| **DSPD – COMMUNITIY PLACEMENT** ***(Division of Services for People with Disabilities)*** | 74 | 74 | 63 | 11 | 39 | 35 |
| **DSPD/OPG** (Division of Services for People with Disabilities/Office of the Public Guardian | 2 | 1 | 2 | 0 | 1 | 1 |
| **DSPD - USDC** (*Utah State Developmental Center)* | 4 | 4 | 0 | 4 | 3 | 1 |
| **OPG** *(Office of the Public Guardian)* | 13 | 13 | 13 | 0 | 6 | 7 |

# CHART I

## FIVE-YEAR COMPARISON

**FY 2004 – FY 2008**

| | FY 2004 | FY2005 | FY 2006 | FY 2007 | FY2008 |
|---|---|---|---|---|---|
| DHS Reported Deaths | 95 | 106 | 100 | 133 | 171 |
| DAAS | 1 | 1 | 0 | 3 | 3 |
| DCFS | 35 | 40 | 31 | 49 | 59 |
| DCFS/DSPD | 2 | 1 | 1 | 1 | 1 |
| DJJS | 1 | 7 | 2 | 3 | 2 |
| DJJS/DCFS | 0 | 0 | 1 | 1 | 2 |
| DMH - USH | 6 | 2 | 2 | 4 | 10 |
| DSPD | 39 | 43 | 57 | 57 | 75 |
| DSPD/OPG | 0 | 0 | 0 | 3 | 2 |
| DSPD – USDC | 8 | 5 | 3 | 3 | 4 |
| OPG | 3 | 7 | 3 | 9 | 13 |
| | | | | | |
| Cases Open at Time of Death | 66 | 76 | 79 | 101 | 124 |
| Reviews Held | 92 | 101 | 97 | 124 | 139 |
| Abuse & Neglect Deaths | 9 | 5 | 6 | 11 | 22 |
| Accidental Deaths | 10 | 13 | 8 | 15 | 10 |
| Homicides | 3 | 4 | 3 | 5 | 14 |
| Motor Vehicle Related Deaths | 2 | 8 | 3 | 5 | 9 |
| Suicides | 2 | 9 | 1 | 4 | 5 |
| Undetermined | 3 | 6 | 7 | 12 | 10 |

# CHART II

## AGE AT TIME OF DEATH

### FY 2008

| AGE IN YEARS | DHS | DAAS | DCFS | DCFS/ DSPD | DJJS | DJJS/ DCFS | DSPD | OPG | USDC | USH |
|---|---|---|---|---|---|---|---|---|---|---|
| < 1 | 25 | | 25 | | | | | | | |
| 1 – 3 | 12 | | 12 | | | | | | | |
| 4- 6 | 7 | | 7 | | | | | | | |
| 7- 10 | 10 | | 7 | | | | 3 | | | |
| 11 - 14 | 6 | | 3 | | | 1 | 2 | | | |
| 15 - 18 | 12 | | 4 | 1 | 2 | 1 | 3 | | | 1 |
| 19 - 30 | 14 | 1 | 1 | | | | 8 | | 1 | 3 |
| 31 – 50 | 37 | | | | | | 34 | | 1 | 2 |
| 51- 65 | 25 | | | | | | 17 | 5 | 1 | 2 |
| 66 – 80 | 16 | 2 | | | | | 9 | 4 | | 1 |
| 81 - 90 | 7 | | | | | | 2 | 4 | | 1 |
| TOTALS | 171 | 3 | 59 | 1 | 2 | 2 | 78 | 13 | 3 | 10 |

# CHART III
## MEDICAL EXAMINER'S DETERMINATION
## MANNER OF DEATH
**FY 2008**

| MANNER OF DEATH | DHS | DAAS | DCFS | DJJS | DSPD | OPG | USDC | USH |
|---|---|---|---|---|---|---|---|---|
| Accident | 10 | | 8 | 1 | 1 | | | |
| Homicide | 14 | | 14 | | | | | |
| Natural Causes | 131 | 3 | 31 | | 74 | 13 | 4 | 6 |
| Pending | 1 | | | | | | | 1 |
| Suicide | 5 | | 2 | | | | | 3 |
| Undetermined | 10 | | 5 | 3 | 2 | | | |
| TOTALS | 171 | 3 | 60 | 4 | 77 | 13 | 4 | 10 |

# CHART IV
## ACCIDENTAL DEATHS
**FY2008**

| CAUSE OF DEATH | GENDER | AGE | DIVISION |
|---|---|---|---|
| Auto/Pedestrian | Female | 16 months | DCFS |
| | Female | 22 months | DCFS |
| | Male | 41 | DSPD |
| Motor Vehicle Accident | Female | 4 | DCFS |
| | Female | 11 | DCFS |
| | Female | 14 | DCFS |
| | Male | 14 | DCFS |
| | Female | 15 | DCFS |
| | Female | 19 | DCFS |
| Fall from Cliff | Male | 5 | DCFS |
| TOTALS | 10 | | |
| Males | 3 | | |
| Females | 7 | | |

# CHART V
## HOMICIDE DEATHS
**FY2008**

| MANNER OF HOMICIDE | GENDER | AGE | DIVISION |
|---|---|---|---|
| Automobile Homicide | Male | 7 | DCFS |
| Blunt Force Injuries to Head and Torso | Female | 6 weeks | DCFS |
| | Female | 2 months | DCFS |
| | Male | 14 months | DCFS |
| | Male | 6 | DCFS |
| Carbon Monoxide Poisoning | Female | 9 | DCFS |
| | Male | 7 | DCFS |
| Conflagration Injuries | Female | 3 | DCFS |
| | Male | 4 | DCFS |
| Drug Intoxication | Female | 3 | DCFS |
| Gunshot Wound | Female | 1 | DCFS |
| | Female | 10 | DCFS |
| Homicidal Asphyxiation (Smothering) | Male | 3 months | DCFS |
| Hypothermia | Male | 9 | DCFS |
| TOTALS | 14 | | |

# CHART VI
## SUICIDE DEATHS
**FY2008**

| MANNER OF SUICIDE | GENDER | AGE | DIVISION |
|---|---|---|---|
| Asphyxia (Hanging) | Female | 21 | USH |
| | Male | 16 | DCFS |
| | Female | 15 | DCFS |
| Gunshot Wound | Male | 22 | USH |
| | Male | 16 | USH |
| TOTAL | 5 | | |

# CHART VII
## ABUSE/NEGLECT DEATHS
### FY 2008

| CAUSE OF DEATH | DHS | GENDER | AGE | DIVISION |
|---|---|---|---|---|
| Asphyxiation | 1 | Male | 3 months | DCFS |
| Automobile Homicide | 1 | Male | 7 | DCFS |
| Blunt Force Injuries - Fall | 1 | Male | 5 | DCFS |
| Carbon Monoxide Poisoning | 1 | Male | 7 | DCFS |
| | 1 | Female | 9 | DCFS |
| Conflagration Injuries | 1 | Female | 3 | DCFS |
| | 1 | Male | 4 | DCFS |
| Dehydration | 1 | Male | 1 month | DCFS |
| Drug Intoxication | 1 | Female | 3 | DCFS |
| Gunshot Wounds | 1 | Female | 1 | DCFS |
| | 1 | Female | 10 | DCFS |
| Hypothermia | 1 | Male | 9 | DCFS |
| Inflicted Injuries | 1 | Female | 6 weeks | DCFS |
| | 1 | Female | 2 months | DCFS |
| | 1 | Male | 13 months | DCFS |
| | 1 | Male | 6 | DCFS |
| Cardio respiratory Failure due to Stroke | 1 | Male | 30 | DSPD |
| Coronary Artery Disease | 1 | Male | 44 | DSPD |
| Pneumonia | 1 | Male | 45 | DSPD |
| Respiratory Arrest | 1 | Male | 57 | DSPD |
| Congestive Heart Failure | 1 | Male | 74 | DSPD |
| Myocardial Infarction | 1 | Female | 79 | DSPD |
| TOTALS | 22 | | | |

# CHART VIII

## FATALITIES BY REGION AND OFFICE

**FY2008**

## DIVISION OF AGING AND ADULT SERVICES

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| Central | 2 | | |
| | | Holladay | 2 |
| Northern | 1 | | |
| | | Ogden | 1 |
| TOTAL | 3 | | 3 |

## DIVISION OF CHILD AND FAMILY SERVICES

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| Eastern | 4 | | |
| | | Price | 1 |
| | | Roosevelt | 3 |
| | | | |
| Northern | 12 | | |
| | | Clearfield | 6 |
| | | Layton | 1 |
| | | Logan | 1 |
| | | Ogden | 4 |
| | | | |
| Salt Lake Valley | 26 | | |
| | | Jackson | 1 |
| | | Magna | 1 |
| | | Mid Towne | 3 |
| | | Oquirrh Neighborhood | 8 |
| | | Salt Lake West | 8 |
| | | South Towne | 1 |
| | | Tooele | 4 |
| | | | |
| Southwest | 7 | | |
| | | Cedar City | 2 |
| | | Manti | 1 |
| | | Richfield | 1 |
| | | St. George | 3 |
| | | | |
| Western | 11 | | |
| | | American Fork | 3 |
| | | Heber City | 1 |
| | | Nephi | 1 |
| | | Orem | 2 |
| | | Provo | 3 |
| | | Spanish Fork | 1 |
| | | | |
| TOTAL | 60 | | 60 |

## DIVISION OF JUVENILE JUSTICE SYSTEMS

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| Region II | 4 | | |
| | | Salt Lake City | 4 |
| TOTAL | 4 | | 4 |

## DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| Central | 25 | | |
| | | Administration | 9 |
| | | Holladay | 14 |
| | | Tooele | 1 |
| | | Vernal | 1 |
| Northern | 16 | | |
| | | Brigham City | 1 |
| | | Clearfield | 7 |
| | | Logan | 1 |
| | | Ogden | 4 |
| | | State Street – SLC | 3 |
| Southern | 36 | | |
| | | American Fork | 14 |
| | | Cedar City | 1 |
| | | Moab | 2 |
| | | Nephi | 2 |
| | | Provo | 9 |
| | | Richfield | 3 |
| | | Spanish Fork | 3 |
| | | St. George | 2 |
| USDC | 4 | | |
| | | American Fork | 4 |
| TOTAL | 81 | | 81 |

## DIVISION OF SUBSTANCE ABUSE and MENTAL HEALTH

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| USH | 10 | | |
| | | Provo | 10 |
| TOTAL | 10 | | 10 |

## OFFICE OF THE PUBLIC GUARDIAN

| REGION | TOTAL | OFFICE | TOTAL |
|---|---|---|---|
| Central | 13 | | |
| | | Administration | 13 |
| | | | |
| TOTAL | 13 | | 13 |